The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 866.895.5975 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 (IU Health/Aetna ASA): $1,500/ individual or $3,000/ family Tier 3 (Out-of-Network): $3,000/individual or $6,000/family Deductible is reduced to $0 once HRA credit is applied for PCG-A team members if care is received at a Tier 1 provider/facility. Does not apply to preventive care by an in-network provider/facility. All copayments and Rx coinsurances do not accumulate toward the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care is covered before you meet your deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-carebenefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 (IU Health/Aetna ASA): $3,750/individual or $7,500/family Tier 3 (Out-of-Network): $7,500/individual or $15,000/family For PCG-A team members, the out-of-pocket limit is reduced to $2,500 for individual coverage and $5,000 for family coverage if care is provided by a Tier 1 provider/facility.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties, premiums, balance billed charges and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See myiuhealthplans.com or call 866.895.5975 for a list of network providers.	You pay the least if you use a provider in Tier 1 (IU Health/Community). You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). "Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: (You will pay the least)	Tier 2 (Pharmacy Only) (You will pay more than Tier 1)	Tier 3: (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit (deductible does not apply)		50% coinsurance	
	Specialist visit	$40/visit (deductible does not apply)		50% coinsurance	
	Preventive care/screening/ immunization	No charge		50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance		50% coinsurance	To determine if a service requires authorization, go to www.myiuhealthplans.com.
	Imaging (CT/PET scans, MRIs)	10% coinsurance		50% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.myiuhealthplans.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: (You will pay the least)	Tier 2 (Pharmacy Only) (You will pay more than Tier 1)	Tier 3: (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myiuhealthplans.com	Tier 1: Preferred generic drugs	30 Day: no charge	30 Day: $4/prescription (deductible does not apply)	30 Day: $25/prescription (deductible does not apply)	The pharmacy network tiers have different names than the medical network tiers: Tier 1: IU Health Pharmacy Tier 2: CVS/Kroger/Payless Pharmacy Tier 3: Preferred Network For a complete list of Rx providers, visit www.myiuhealthplans.com
		90 Day: no charge	90 Day: not covered	90 Day: not covered	
	Tier 2: Generic drugs	30 Day: $5/prescription (deductible does not apply)	30 Day: $10/prescription (deductible does not apply)	30 Day: $25/prescription (deductible does not apply)	
		90 Day: $10/prescription (deductible does not apply)	90 Day: not covered	90 Day: not covered	
	Tier 3: Preferred brand and selected generic drugs	30 Day: $20/prescription (deductible does not apply)	30 Day: $30/prescription (deductible does not apply)	30 Day: $50/prescription (deductible does not apply)	
		90 Day: $40/prescription (deductible does not apply)	90 Day: not covered	90 Day: not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: (You will pay the least)	Tier 2 (Pharmacy Only) (You will pay more than Tier 1)	Tier 3: (You will pay the most)	
	Tier 4: Non-preferred brand and non-preferred generic drugs	30 Day: 20% coinsurance ($50 min and $100 max)	30 Day: 30% coinsurance ($50 min and $100 max)	30 Day: 50% coinsurance ($150 min and $300 max)	
		90 Day: 20% coinsurance ($150 min and $300 max)	90 Day: not covered	90 Day: not covered	
	Tier 5: Specialty drugs	30 Day: 25% coinsurance ($75 min and $250 max)		30 Day: not covered	
		90 Day: not covered			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance		50% coinsurance	To determine if a service requires authorization, go to www.myiuhealthplans.com.
	Physician/surgeon fees	10% coinsurance		50% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance		10% coinsurance	Benefits will be covered as a Tier 1 benefit. No coverage for non-emergent services provided in the ER.
	Emergency medical transportation	10% coinsurance		10% coinsurance	
	Urgent care	$25/visit (deductible does not apply)		$25/visit (deductible does not apply)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance		50% coinsurance	Preauthorization required.
	Physician/surgeon fees	10% coinsurance		50% coinsurance	Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: (You will pay the least)	Tier 2 (Pharmacy Only) (You will pay more than Tier 1)	Tier 3: (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $25/visit (deductible does not apply) Other Outpatient: 10% coinsurance		Office Visit: 50% coinsurance Other Outpatient: 50% coinsurance	To determine if a service requires authorization, go to www.myiuhealthplans.com
	Inpatient services	10% coinsurance		50% coinsurance	
If you are pregnant	Office visits	$40/visit (deductible does not apply)		50% coinsurance	
	Childbirth/delivery professional services	10% coinsurance		50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance		50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance		50% coinsurance	
	Rehabilitation services	$40/visit		50% coinsurance	60 visit limit combined Occupational Therapy/Physical Therapy and separate 20 visit limit for Speech Therapy. Preauthorization required if done in-home.
	Habilitation services	Not covered		Not covered	
	Skilled nursing care	10% coinsurance		50% coinsurance	Preauthorization required.
	Durable medical equipment	10% coinsurance		50% coinsurance	Preauthorization required.
	Hospice services	10% coinsurance		50% coinsurance	Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: (You will pay the least)	Tier 2 (Pharmacy Only) (You will pay more than Tier 1)	Tier 3: (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$35/visit		$50 allowance	You pay the least if you use an EyeMed Insight or IU Health contracted provider (Tier 1). You will pay the most if you use an out-of-network provider (Tier 3), and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
	Children's glasses	35% discount		Not covered	Coverage is limited to EyeMed Insight network providers
	Children's dental check-up	Not covered		Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (rendered in a hospital or skilled nursing facility)
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic Care
- Refractive eye exam
- Infertility treatment ($15,000 lifetime limit)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact Indiana University Health Plans, 950 N. Meridian St. Suite 400, Indianapolis, IN 46204, Phone No. 866-895-5828, TTY: 800-743-3333 and the Indiana State Department of Insurance, 311 W. Washington St. Suite 300, Indianapolis, IN 46204, Phone No. 317-232-2395. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

* For more information about limitations and exceptions, see the plan or policy document at www.myiuhealthplans.com.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Indiana University Health Plans ATTN: Grievances, 950 N. Meridian St., Suite 400, Indianapolis, IN 46204, 866-895-5828, TTY: 800-743-3333. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [800.455.9776].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [800.455.9776].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[800.455.9776].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [800.455.9776].]

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,500**
Specialist *copayment*	**40**
Hospital (facility) *coinsurance*	**10%**
Other *coinsurance*	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,670**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist *copayment*	**$40**
Hospital coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,500**
Specialist *copayment*	**$40**
Hospital coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1500
Copayments	$300
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,860**

The plan would be responsible for the other costs of these EXAMPLE covered services.

IU Health does not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, genetic information, veteran status, national origin, gender identity and/or expression, marital status, or any other characteristic protected by federal, state, or local law.

Indiana University Health Plans:

Provides free aids and services to people with disabilities to communicate effectively with us,such as:
– Qualified sign language interpreters

– Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
– Qualified interpreters

– Information written in other languages

If you need these services, contact IU Health Plans Customer Service at 800.455.9776.

If you believe that Indiana University Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Indiana University Health Plans, 950 N.Meridian St. Suite 400, Indianapolis, IN 46204; 866.895.5975, (TTY/TDD: 711); Fax 317.963.9801;IUHPlansCompliance@iuhealth.org.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, IU Health Plans' Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 509F, HHH Building
Washington, D.C. 20201
T 800.368.1019
T 800.537.7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at [1- 800-455-9776]. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al [1-800- 455-9776]. Alguien que hable español le podrá ayudar. Este es unservicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-455-9776。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-455-9776。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa [1-800-455-9776]. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au [1-800-455-9776]. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi [1-800-455-9776] sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet IhrenFragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter [1-800-455-9776]. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 [1-800-455- 9776]번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону [1-800-455-9776]. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديك. للحصول على هذه الخدمة المجانية، يرجى الاتصال بنا على [1-800-455-9776]. سيقوم شخص ما يتحدث العربية بمساعدتك.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब देने के लिए हमार पास मुफ्त दुभाषिया सेवाएँ उपलब्ध ह एक दुभ ाषिया प्राप्त करने के लिए बस हमें [पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero [1-800-455-9776]. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número [1- 800-455-9776]. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan [1-800-455-9776]. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer [1-800-455-9776]. Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、[1-800-455- 9776]にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。